

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				13735	
13765				CERTIFICATE OF DEATH	
Reg. Dist. No.				13735	
1. PLACE OF DEATH a. COUNTY <b>Charles</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
c. LENGTH OF STAY IN b <b>3 Months</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES CLIFFORD</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>4</b> Year <b>1960</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>August 21, 1960</b>		9. AGE (In years last birthday) yrs. <b>3</b> IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b>19</b> Min. <b>60</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Edward Barber</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Barber</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mr.s Evelyn Barber - La Plata, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>12-1</b> , 19 <b>60</b> , to <b>12-4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12-1</b> , 19 <b>60</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>12-4-60</b>		ADDRESS (Street, city or town, state) <b>LA PLATA, Md.</b>	
PHYSICIAN'S NAME (Type) <b>F. M. Johnson, M.D.</b>		La Plata, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>12/5/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>La Plata, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>Archart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 6 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		DATE <b>DEC 6 '60</b>		24c. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

4000181XV4

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

13766  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 7 Film G277 12-21-60 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

13736

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md c. LENGTH OF STAY IN 1b 30-Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Indian Head Md d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harry Lee Besley First Middle Last 4. DATE OF DEATH 12-8-60 Day Year 19						
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-28-1896	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Maintainance		11. BIRTHPLACE (State or foreign country) Spencer, New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ruben Besley		14. MOTHER'S MAIDEN NAME Bertha Lawrence				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes USMC		16. SOCIAL SECURITY NO.		17. INFORMANT Address Edgar Besley (Brother) Indian Head Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Carcinoma Pancreas With Liver Metastasis Indefinite DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition due to liver involvement 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-10-60, 19, to 12-8-60, 19, that I last saw the deceased alive on 12-8-60, 19, and that death occurred at 5-PM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. Indian Head Md 12-9-60 PHYSICIAN'S NAME (Type) James E. Andrews MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Horth Funeral Home Waldorf Md				24a. REC'D BY REGISTRAR DATE DEC 15 '60		24b. REGISTRAR'S SIGNATURE [Signature]



13767

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Newport</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Newport</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>THOMAS</i> First Middle Last <i>BOWMAN</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>7</i> Year <i>1960</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-5-1884</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Steven I. Bowman</i>	
14. MOTHER'S MAIDEN NAME <i>Mary J. Thomas</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>William H. Bowman</i>		INFORMANT Address <i>4236 Bennington Rd NE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>metastatic carcinoma of undetermined origin 1 year</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1957</i> to <i>12-6-60</i> , that I last saw the deceased alive on <i>July 1960</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>LA PLATA, Md. 12-7-60</i>			
ACTUAL SIGNATURE <i>Trigler</i>		M.D. <i>LA PLATA, Md. 12-7-60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/10/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>	22d. LOCATION (City, town, or county) (State) <i>Newport, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley</i>		ADDRESS <i>Leonardtwn, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1

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VS AIS (4)  
ISM 9/58

CERTIFICATE OF DEATH

1888

11

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe



13768

CERTIFICATE OF DEATH

Reg. Dist. No.

13738

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural PISGAH</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>DEWEY</u> Middle <u>CARPENTER</u> Last				4. DATE OF DEATH <u>DECEMBER</u> Month <u>21</u> Day <u>1960</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/1897</u>	9. AGE (In years last birthday) yrs. <u>63</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles D. Carpenter</u>				14. MOTHER'S MAIDEN NAME <u>Sarah A. Braguner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		INFORMANT Address <u>Mrs. Cecelia B. Carpenter - Pisgah, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last: (b) <u>Myocardial infarction</u> DUE TO (c) <u>Hypertensive heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Dec</u> , 19 <u>60</u> , to <u>21 Dec</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>21 Dec</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>La Plata, Maryland</u> DATE SIGNED <u>21 Dec 60</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>La Plata, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pisgah Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pisgah, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Archart Funeral Home, Inc. La Plata, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10708

STATE OF NEW YORK  
DEPARTMENT OF AGRICULTURE  
OFFICE OF THE COMMISSIONER  
ALBANY, N. Y.  
JANUARY 1, 1908

TO THE HONORABLE  
THE COMMISSIONER OF AGRICULTURE  
STATE OF NEW YORK  
ALBANY, N. Y.

SIR:

I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the matter of the application for a license to sell and distribute the product of the State of New York, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours obediently,  
J. B. ALLEN,  
Commissioner of Agriculture.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13769 CERTIFICATE OF DEATH

Reg. Dist. No. **13739**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Charles</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA Plaza</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Dentsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial</b>				e. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Philip</b> Middle <b>Alexander</b> Last <b>Cusick</b>				<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>8</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 22, 1778</b>	
<b>9. AGE</b> (In years last birthday) <b>82 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____		<b>IF UNDER 24 HRS.</b> Months _____ Days _____ Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>William Cusick</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lucy Kaywood</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Harry Cusick, Newport, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Glaucoma</b> DUE TO (c) <b>Glaucoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>				<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <b>11-2-60</b> , <b>1960</b> , to <b>12-8-60</b> , that I last saw the deceased alive on <b>12-7-60</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) <b>F. J. EDELLEN</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12-12-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St Peters</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Waldorf, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The Hunt Funeral Home, Waldorf, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DEC 15 1960</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles E. Fennell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1878

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
BIRTH DATE <i>Jan 15 1833</i>		BIRTH PLACE <i>Dover, N.H.</i>		MARRIAGE DATE <i>Nov 10 1855</i>		MARRIAGE PLACE <i>Dover, N.H.</i>	
OCCUPATION <i>Farmer</i>		CAUSE OF DEATH <i>Heart Disease</i>		DATE OF DEATH <i>Dec 10 1878</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF WITNESS <i>W. J. Brown</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF NEAREST RELATIVE <i>Mary Doe</i>	
CERTIFICATE OF DEATH		DECEASED		DATE OF DEATH		PLACE OF DEATH	

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13740

13770

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>INEZ</b> Middle <b>V.</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN 7, 1926</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MORRIS Mc CREADY</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Coleman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>ARTHUR DAVIS, WALDORF, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO (b) <b>SCE of Endocervix</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b> <b>1 YR.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 12, 1960</b> to <b>Dec 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 12, 1960</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. PARRAN JARBOE</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE MD</b>		22d. ADDRESS <b>La Plata, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-16-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>WALDORF, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE DEC 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1917

Chlorine

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From the report of the 2nd day

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13741**

**13771**

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>		c. LENGTH OF STAY IN 1b <b>17 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hughesville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Gertrude</b> Last <b>Dean</b>				4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-9-93</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>12</b> Min. <b>14</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John I. Williams</b>				14. MOTHER'S MAIDEN NAME <b>??</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>William L. Duane Hughesville, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Carbon Gas Valve Defect</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>12-14-60</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. T. DeLeon</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>E. T. DELEON</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>12-14-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>		22d. LOCATION (City, town, or county) (State) <b>Morgantown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Hattley</b>				ADDRESS <b>Lordsburg, Md</b>		24a. REC'D BY REGISTRAR <b>DEC 20 1960</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.







1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# 13772 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) <i>BARRETT Gregory DOUGLAS</i>				4. DATE OF DEATH Month <i>12</i> Day <i>14</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-20-60</i>	9. AGE (In years last birthday) <i>9</i> yrs.	IF UNDER 4 YEARS Months <i>9</i> Days <i>24</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Chas Co Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Columbus Brown</i>				14. MOTHER'S MAIDEN NAME <i>MARY Catherine Douglas</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>N.</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>"</i> Address <i>Hughesville, Charles</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO <i>Bronchitis Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>9</i> p.m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. J. EDELEN</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <i>12-14-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/19/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>La Plata, Maryland</i>	
23. FUNERAL DIRECTOR <i>Arehart Funeral Home</i> ADDRESS <i></i>				24a. REC'D BY REGISTRAR <i>DEC 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

4000245XV6

100000

THE STATE  
DEPARTMENT

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
100 NORTH STREET, BOSTON, MASSACHUSETTS  
FEBRUARY 1900

Birth Record of  
[Name] born [Date]  
at [Location]  
to [Parents]  
[Signature]  
[Title]

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
100 NORTH STREET, BOSTON, MASSACHUSETTS  
FEBRUARY 1900

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13743

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANS RD</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <u>1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>RANDOLPH</u> First Middle Last			4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1960</u>		
5. SEX <u>M</u>			6. COLOR OR RACE <u>C</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8-18-1899</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>fed. Govt.</u>		
11. BIRTHPLACE (State or foreign country) <u>St. Thomas, V.I.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>? deceased</u>			14. MOTHER'S MAIDEN NAME <u>? deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>deceased</u>			16. SOCIAL SECURITY NO. <u>deceased</u>		
17. INFORMANT <u>Prane T. Furey - Bryans Road, Md</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. J. EDELEN</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>12-20-60</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Methodist</u>			22d. LOCATION (City, town, or country) (State) <u>Pomomoy, Md.</u>		
23. FUNERAL DIRECTOR <u>Barnes Matthews 3619-14" S.W. Wash, DC</u>			ADDRESS		
24a. REC'D BY REGISTRAR <u>DEC 19 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Furey</u>		

MEDICAL CERTIFICATION

STATE OF NEW YORK  
IN SENATE  
JANUARY 13, 1915  
REPORT  
OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF HEALTH  
ON THE  
MORBIDITY AND MORTALITY  
IN THE STATE OF NEW YORK  
DURING THE YEAR 1914  
ALBANY: J.B. LIPPINCOTT COMPANY, 1915.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14597

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GRAYTON (rural) life</b>		c. LENGTH OF STAY IN 1b <b>life</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grayton</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b>		First <b>LOUISE</b>		Middle <b>GASSAWAY</b>		Last		4. DATE OF DEATH <b>DECEMBER 2 1960</b>		Month <b>DECEMBER</b>		Day <b>2</b>		Year <b>1960</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/5/60</b>		9. AGE (In years last birthday) yrs. <b>4</b> Months <b>27</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>27</b>		IF UNDER 24 HRS. Hours <b>27</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Chas. Co. Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>ARTHUR GASSAWAY</b>				14. MOTHER'S MAIDEN NAME <b>MARY BERTHA HENSON</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>FATHER, GRAYTON, MD.</b>				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prob. Pneumonia</b> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Had minor respiratory ailment for 2 days</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found dead in bed at 2 A.M. on 12-2-'60</b>												INTERVAL BETWEEN ONSET AND DEATH <b>12-2-'60</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>B. J. EDELEN</b> DATE SIGNED <b>12-2-'60</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <b>Father Grayton, Md.</b>				ADDRESS <b>4000416'XV6</b>				24a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Funn</b>			

VS. A15ME  
SM 9/60  
4/10/61  
mn b

14503



*John J. Murphy*

*John J. Murphy*

*John J. Murphy*



1

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13774

CERTIFICATE OF DEATH

Reg. Dist. No. 13746

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PHYSICIANS MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RICHARD M. GOLDEN</u>		4. DATE OF DEATH <u>DEC 25 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/1889</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mailman - farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Julius S. Golden</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Willott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-366235</u>	
17. INFORMANT <u>WIFE</u> Address <u>Route 1 Box 57 Nanjemoy, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> <u>490X</u> DUE TO <u>Pneumonia, lobar</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>7 days</u> (c) <u>Upper respiratory infection</u> <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSON SYNDROME</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>49</u> , to <u>Dec 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>25 Dec 60</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.		ADDRESS (Street, city or town, state) <u>JARWOOD CLINIC</u> DATE SIGNED <u>25 DEC 60</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		<u>LAPLATA MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Baptist Church</u>	22d. LOCATION (City, town, or county) (State) <u>Nanjemoy, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart</u> ADDRESS <u>Archart Funeral Home, Inc. - La Plata, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1872  
Coxsack

1. Name of deceased: *John A. Smith*  
2. Age: *45*  
3. Sex: *Male*  
4. Date of death: *Jan 15 1872*  
5. Place of death: *Coxsack*  
6. Cause of death: *Consumption*  
7. Signature of physician: *Dr. J. W. Smith*  
8. Signature of registrar: *Wm. A. Smith*  
9. Date of registration: *Jan 16 1872*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13745

477X-3

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		
c. LENGTH OF STAY IN 1b <b>TRANS</b>			d. STREET ADDRESS <b>2108 I St N.E.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NONE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CARL Luther Headen</b>			4. DATE OF DEATH <b>Dec 9 1960</b>		
5. SEX <b>M</b>			6. COLOR OR RACE <b>C</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>JULY 1939</b>		
9. AGE (In years last birthday) <b>21 yrs.</b>			10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>CLAUDE Headen</b>			14. MOTHER'S MAIDEN NAME <b>CALLIE HEART</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		
17. INFORMANT <b>ROLAND Headen</b>			Address <b>Pittsboro NC</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>812X</b> <b>COMPOUND FRACTURE SKULL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>MULTIPLE FRACTURES OF LEGS</b> DUE TO (c) <b>12-9-60</b>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>PEDESTRIAN Hit By Auto</b> <b>12-9-60</b>		
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			22. TIME OF INJURY Month, Day, Year <b>11 12-9-60</b>		
23. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		
25. (City or town) <b>WALDORF CHAS MD</b>			26. (County) (State)		
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
29. ACTUAL SIGNATURE <b>E. J. EPELEN</b>			30. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
31. EXAMINER'S NAME (Type) <b>E. J. EPELEN</b>			32. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
33. Address (Street, city, town, or county) <b>12-9-60</b>			34. DATE SIGNED		
35. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			36. DATE THEREOF <b>12-15-60</b>		
37. NAME OF CEMETERY OR CREMATORY <b>UNION GROVE</b>			38. LOCATION (City, town, or country) (State) <b>Pittsboro, N.C.</b>		
39. FUNERAL DIRECTOR <b>HONTT FUNERAL HOME</b>			40. ADDRESS <b>WALDORF MD</b>		
41. REC'D BY REGISTRAR <b>DEC 15 '60</b>			42. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

1972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: CARL LUTHER  
AGE: 45  
SEX: M  
RACE: W

DATE OF BIRTH: 12-15-27  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]

RESIDENCE: [illegible]  
CAUSE OF DEATH: [illegible]

DATE OF DEATH: 11-15-72  
PLACE OF DEATH: [illegible]

SIGNATURE: [illegible]  
TITLE: [illegible]

DATE: 11-15-72  
PLACE: [illegible]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MALCOLM</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>16X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>D</b> Last <b>Henson</b>					4. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>1960</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/15/1912</b>		9. AGE (In years last birthday) <b>48</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>usa</b>		
13. FATHER'S NAME <b>Benjamin Henson</b>					14. MOTHER'S MAIDEN NAME <b>Ernie Monrol</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> <b>812X</b> DUE TO <b>COMPOUND FRAC SKULL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>PEDESTRIAN HIT BY AUTO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>12-11-60</b> <b>12-11-60</b> <b>12-11-60</b>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>HIT BY AUTO</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12-11-1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>MALCOLM</b> (County) <b>CHARS</b> (State) <b>MD.</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>E. J. EDELEN</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>					22b. DATE THEREOF <b>12/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas</b>		22d. LOCATION (City, town, or country) (State) <b>Brandywine Md.</b>	
23. FUNERAL DIRECTOR <b>George H. Nelson</b>					ADDRESS <b>Aguasco Md</b>		24a. REC'D BY REGISTRAR <b>DEC 19 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>		d. STREET ADDRESS <b>Waldorf</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Laws</b> Last		4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Laws</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-44-3644</b>	
17. INFORMANT <b>Mrs. T. H. Medley</b>		Address <b>Waldorf, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Pneumonia, Terminal</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Demility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>10/4/59</b> to <b>12-18-60</b> , that (1) (we) last saw the deceased alive on <b>Dec-18-1960</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>George Weber M.D.</b>		22b. DATE SIGNED <b>12-20-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Weber M.D.</b>		22d. ADDRESS <b>Waldorf, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12 21 60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>		24. ADDRESS <b>Waldorf, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1877

CERTIFICATE OF DEATH

1877

Blank form with faint horizontal lines and vertical columns for data entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13778

## CERTIFICATE OF DEATH

Reg. Dist. No. 13748

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Charles b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp. LaPlata Md		d. STREET ADDRESS 3228 Riverview Village Indian Head Md	
3. NAME OF DECEASED (Type or print) Ruth Margeret Manes		4. DATE OF DEATH xx2*29* 12-29-60	
5. SEX Female	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-97
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) USA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME David O. Crouch		14. MOTHER'S MAIDEN NAME Missouri Goodhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Madge Manes-Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver, Primary 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH Indefinite	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1-54, 19, to 12-29-60, 19, that I last saw the deceased alive on 12-29-60, 19, and that death occurred at 3-32A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Andrews		ADDRESS (Street, city or town, state) DATE SIGNED Indian Head Md 12-29-60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Archant Funeral Home - LaPlata, Md		24a. REC'D BY REGISTRAR JAN 3 '61	
24b. REGISTRAR'S SIGNATURE Arthur J. House			

CERTIFICATE OF DEATH

1278

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1890</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>12-10-1960</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>12-15-1960</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	
<p>13. Name of informant: <u>JOHN J. SMITH</u></p>		<p>14. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>15. Name of informant: <u>JOHN J. SMITH</u></p>		<p>16. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>17. Name of informant: <u>JOHN J. SMITH</u></p>		<p>18. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>19. Name of informant: <u>JOHN J. SMITH</u></p>		<p>20. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>21. Name of informant: <u>JOHN J. SMITH</u></p>		<p>22. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>23. Name of informant: <u>JOHN J. SMITH</u></p>		<p>24. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>25. Name of informant: <u>JOHN J. SMITH</u></p>		<p>26. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>27. Name of informant: <u>JOHN J. SMITH</u></p>		<p>28. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>29. Name of informant: <u>JOHN J. SMITH</u></p>		<p>30. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>31. Name of informant: <u>JOHN J. SMITH</u></p>		<p>32. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>33. Name of informant: <u>JOHN J. SMITH</u></p>		<p>34. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>35. Name of informant: <u>JOHN J. SMITH</u></p>		<p>36. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>37. Name of informant: <u>JOHN J. SMITH</u></p>		<p>38. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>39. Name of informant: <u>JOHN J. SMITH</u></p>		<p>40. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>41. Name of informant: <u>JOHN J. SMITH</u></p>		<p>42. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>43. Name of informant: <u>JOHN J. SMITH</u></p>		<p>44. Address of informant: <u>1234 MAIN ST.</u></p>	
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<p>49. Name of informant: <u>JOHN J. SMITH</u></p>		<p>50. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>51. Name of informant: <u>JOHN J. SMITH</u></p>		<p>52. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>53. Name of informant: <u>JOHN J. SMITH</u></p>		<p>54. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>55. Name of informant: <u>JOHN J. SMITH</u></p>		<p>56. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>57. Name of informant: <u>JOHN J. SMITH</u></p>		<p>58. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>59. Name of informant: <u>JOHN J. SMITH</u></p>		<p>60. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>61. Name of informant: <u>JOHN J. SMITH</u></p>		<p>62. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>63. Name of informant: <u>JOHN J. SMITH</u></p>		<p>64. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>65. Name of informant: <u>JOHN J. SMITH</u></p>		<p>66. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>67. Name of informant: <u>JOHN J. SMITH</u></p>		<p>68. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>69. Name of informant: <u>JOHN J. SMITH</u></p>		<p>70. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>71. Name of informant: <u>JOHN J. SMITH</u></p>		<p>72. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>73. Name of informant: <u>JOHN J. SMITH</u></p>		<p>74. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>75. Name of informant: <u>JOHN J. SMITH</u></p>		<p>76. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>77. Name of informant: <u>JOHN J. SMITH</u></p>		<p>78. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>79. Name of informant: <u>JOHN J. SMITH</u></p>		<p>80. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>81. Name of informant: <u>JOHN J. SMITH</u></p>		<p>82. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>83. Name of informant: <u>JOHN J. SMITH</u></p>		<p>84. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>85. Name of informant: <u>JOHN J. SMITH</u></p>		<p>86. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>87. Name of informant: <u>JOHN J. SMITH</u></p>		<p>88. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>89. Name of informant: <u>JOHN J. SMITH</u></p>		<p>90. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>91. Name of informant: <u>JOHN J. SMITH</u></p>		<p>92. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>93. Name of informant: <u>JOHN J. SMITH</u></p>		<p>94. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>95. Name of informant: <u>JOHN J. SMITH</u></p>		<p>96. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>97. Name of informant: <u>JOHN J. SMITH</u></p>		<p>98. Address of informant: <u>1234 MAIN ST.</u></p>	
<p>99. Name of informant: <u>JOHN J. SMITH</u></p>		<p>100. Address of informant: <u>1234 MAIN ST.</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAPLATA MD.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Laplata</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>(Rural)</u>		d. STREET ADDRESS <u>1 Rural</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL ORVILLE MARSHALL</u>		4. DATE OF DEATH Month Day Year <u>12 16 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>on farm.</u>	9. AGE (In years last birthday) <u>52 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL MARSHALL</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Washington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>Unknown.</u>	
17. INFORMANT <u>Ethel Gray</u>		Address <u>1234 E. St. SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-16-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EIDLEN</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EIDLEN</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec-20-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Harmony Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR <u>John T. Rhines &amp; Co.</u>		ADDRESS <u>3015 12th Street, N. E.</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13780 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 7 Film 6278 1-5-61 et 13750											
1. PLACE OF DEATH a. COUNTY <u>Charles</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Ches</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pisgah (home)</u>				c. LENGTH OF STAY in 1b <u>Life</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MD (home)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ARTHUR</u> First Middle Last				4. DATE OF DEATH <u>MONROE</u> Month <u>12</u> Day <u>17</u> Year <u>1960</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-91</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W.F.F.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Powder Factory</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Monroe</u>				14. MOTHER'S MAIDEN NAME <u>Luckitia Miles</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>377032487</u>				17. INFORMANT <u>ERTHA Digger Pisgah Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260 X</u> DUE TO <u>LOBAR PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIABETES</u> (c) <u>DIABETES</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12-14-60</u> <u>12-17-60</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. J. Edelen</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-17-60</u>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Bapt. Chur.</u>				22d. LOCATION (City, town, or country) (State) <u>Marlboro, Md.</u>			
23. FUNERAL DIRECTOR <u>Travis R. Carter &amp; Co.</u>				ADDRESS <u>305-H St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

WASH., D.C.

THE STATE  
OF NEW YORK

IN SENATE  
JANUARY 1, 1910

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1899

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS, 1910.

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13781

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13751

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>X</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Baby Middle Girl Last Moore</b>		4. DATE OF DEATH <b>Dec. 12, 1960 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-60</b>
9. AGE (In years last birthday) <b>10</b>		10. IF UNDER 1 YEAR Months Days Hours	
11. IF UNDER 24 HRS. <b>10</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sherwood Leslie Moore</b>		14. MOTHER'S MAIDEN NAME <b>Lois Flater Bowie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Lois Moore</b>		Address <b>La Plata, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anoxia,</b> <b>762.5</b> DUE TO <b>prematurity and inability of respiratory</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>apnea to fracture</b> (c) <b>apnea to fracture</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/2/60</b> 19 <b>12/2/60</b> , that (I) (we) last saw the deceased alive on <b>12/2/60</b> 19 <b>12/2/60</b> , and that death occurred at <b>8:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>A. O. Woody</b>		22b. DATE SIGNED <b>13 Dec 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. O. Woody, M.D.</b>		22d. ADDRESS <b>La Plata, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/15/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Waldorf, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 20 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13782 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G278 1-4-61 et

Reg. Dist. No. 13252

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Robert Moreland		4. DATE OF DEATH December 19 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7 1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days 19	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		12. KIND OF BUSINESS OR INDUSTRY farming	
13. BIRTHPLACE (State or foreign country) Charles Co. Md.		14. CITIZEN OF WHAT COUNTRY USA	
15. FATHER'S NAME ELZAR Moreland		16. MOTHER'S MAIDEN NAME Mary C. Burch	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO.	
19. INFORMANT Robert A. Moreland		Address Waldorf, Md.	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 12-12-60 12-19-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		22b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward J. Edelen		DATE SIGNED	
EXAMINER'S NAME (Type) Edward J. Edelen M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE THEREOF 12-24-60	
24c. NAME OF CEMETERY OR CREMATORY ST. Peters Cemetery		24d. LOCATION (City, town, or county) (State) Waldorf, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS Waldorf, Md.	
26a. REC'D BY REGISTRAR DATE DEC 27 '60		26b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





13783

CERTIFICATE OF DEATH

Reg. Dist. No. 13753

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomonkey La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomonkey-Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp. LaPlata Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edmund</u> Middle <u>Burt</u> Last <u>Owens</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W-US</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-3-1867</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Practice of Medicine</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Wesley Owens</u>				14. MOTHER'S MAIDEN NAME <u>Mary Silverthorne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1917-1919</u>		17. INFORMANT <u>Paul Keller-(Step Son)</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>450.0</u> DUE TO <u>Arterio-Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>Age</u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10-Days</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>10-1-60</u> , 19 <u>  </u> , to <u>12-26-60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>12-26-60</u> , 19 <u>  </u> , and that death occurred at <u>4-45 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Andrews</u> M.D. <u>Indian Head Md.</u>				DATE SIGNED <u>12-27-60</u>			
PHYSICIAN'S NAME (Type) <u>James E. Andrews</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13754**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>Charles</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Charles Co Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Wicomico</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Charles Co Md. Wicomico</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>				d. STREET ADDRESS <b>1</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Barbara Regina</b> First Middle Last				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>2</b> Year <b>1960</b>			
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>C</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5/6/1950</b>		<b>9. AGE</b> (In years last birthday) <b>10</b> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Newburg Md.</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Robert V. Powell dec.</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Viola C. Powell dec.</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>916.0</b> <b>Conflagration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>House fire</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>7</b> p. m. <b>12-2</b> 19 <b>60</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
<b>20f. (City or town)</b> <b>Wicomico</b>		<b>20g. (County)</b> <b>Charles</b>		<b>20h. (State)</b> <b>Md.</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>E. J. EDEN</b>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <b>12-2-60</b>			
<b>EXAMINER'S NAME (Type)</b> <b>E. J. EDEN</b>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12/5/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St Mary's</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Newport Maryland</b>		<b>22e. (State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Johnson &amp; Jenkins, 4804 Ga Ave N.W.</b>			<b>24a. REC'D BY REGISTRAR</b> <b>DEC 6 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12  
12-1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13785

Reg. Dist. No. 13755

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Charles Co Md.</u> COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co Md. Wicomico</u> life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co Md Wicomico</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>HENRY</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1948</u>		9. AGE (In years last birthday) <u>12</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newberg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert V. Powell dec.</u>				14. MOTHER'S MAIDEN NAME <u>Viola C. Powell dec.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conflagration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <u>12-2-60</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House fire</u> <u>12-2-60</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> a. m. <u>12-2</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wicomico Charles Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-2-60</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Newport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins 4804 Ga Ave N.W.</u>				24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED <b>JAMES</b></p>		<p>RESIDENCE <b>1111</b></p>	
<p>DATE OF DEATH <b>11-11-1911</b></p>		<p>PLACE OF DEATH <b>HOME</b></p>	
<p>AGE <b>45</b></p>		<p>SEX <b>MALE</b></p>	
<p>CAUSE OF DEATH <b>HEART DISEASE</b></p>		<p>MANNER OF DEATH <b>NATURAL</b></p>	
<p>DATE OF EXAMINATION <b>11-11-1911</b></p>		<p>PLACE OF EXAMINATION <b>HOME</b></p>	
<p>SIGNATURE OF EXAMINER <b>ROBERT W. FOWLER, M.D.</b></p>		<p>DATE OF SIGNATURE <b>11-11-1911</b></p>	
<p>TESTIMONY OF EXAMINER I, the undersigned, being duly sworn, depose and say that the foregoing is a true and correct statement of the facts as the same appeared to me at the time and place above stated.</p>		<p>SUBSCRIBED AND SWORN TO before me this 11th day of November, 1911.</p>	
<p>NOTARY PUBLIC <b>JOHN C. FOWLER</b></p>		<p>COMMISSION EXPIRES <b>11-11-1912</b></p>	



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VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13786 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13756

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Charles Co Md.</u> b. COUNTY <u>Chas.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wicomico Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co Md. Wicomico</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>Allen</u> Middle <u>Powell</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/9151</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Robert V. Powell dec.</u>	
14. MOTHER'S MAIDEN NAME <u>Viola C. Powell dec.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>Congestive</u> Candidiasis, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12-2-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House fire</u>		20c. TIME OF INJURY Month, Day, Year <u>12-2-1960</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Wicomico</u> (County) <u>Charles</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-2-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Newport Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins 4804 Ga Ave N.W.</u>		24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

5128

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. No burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13757

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Charles Co Md.</u> COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co Md. Wicomico</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co Md Wicomico</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>--</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Joseph A Powell</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/1957</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Norristown Pennsylvania USA</u>		
11. BIRTHPLACE (State or foreign country) <u>Norristown Pennsylvania USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert V. Powell</u>		14. MOTHER'S MAIDEN NAME <u>IDA Powell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		
17. INFORMANT <u>---</u>		Address <u>---</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conflagration</u> DUE TO <u>9/16/60</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>---</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12-2-60</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House fire 12-2-60</u>		
20c. TIME OF INJURY Month, Day, Year <u>12-2-1960</u> Hour <u>7</u> a.m. <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Wicomico Ches</u> (County) <u>MD</u> (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-2-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/60</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>ST Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Newport Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins 4804 Ga Ave N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

13788 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13758

1. PLACE OF DEATH a. COUNTY <i>Charles Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Wicomico</i> Md. b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charles Co Md. Wicomico</i>		c. LENGTH OF STAY IN life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charles Co Md Wicomico</i>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <i>12</i> Day <i>2</i> Year <i>1960</i>	
3. NAME OF DECEASED (Type or print) <i>ROBERT</i> First Middle Last		5. SEX <i>M</i>	
6. COLOR OR RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>5/3/1915</i>		9. AGE (In years last birthday) <i>45</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	
11. BIRTHPLACE (State or foreign country) <i>Newport Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conflagration</i> DUE TO <i>House fire</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>House fire</i> DUE TO (c) <i>House fire</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12-2-60</i> <i>12-2-60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>House fire</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>12-2-1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Wicomico</i> (County) <i>Charles</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Fedele</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. FEDELE</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>12-2-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/5/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Newport Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson &amp; Jenkins</i>		ADDRESS <i>4804 Ga Ave N.W.</i>	
24a. REC'D BY REGISTRAR <i>DEC 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haus</i>	



DEATH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		60		M		W		1890		BALTIMORE		MD		USA		USA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		RELIGION		POLITICAL PARTY		SOCIETY		OTHER	
1234 E. BALTIMORE ST.		DRIVER		HIGH SCHOOL		MARRIED		NONE		METHODIST		DEMOCRAT		NONE		NONE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
JAN 15 1950		10:00 AM		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NONE		NONE	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		CITY		STATE		COUNTRY		OTHER		OTHER	
J. H. HARRIS		DR. HARRIS		JAN 15 1950		BALTIMORE		MD		USA		USA		USA		USA	



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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13789

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13759

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Charles Co</u> <u>MD</u> COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co MD Wicomico</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co MD Wicomico</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VIOLA</u> Middle <u>Powell</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/3/1915</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newport Md.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9/16.0</u> <u>Conflagration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>House fire 12-2-60</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> a. m. <u>12-2</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wicomico Charles MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Co</u>		22d. LOCATION (City, town, or county) (State) <u>Newport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins 4804 Ga Ave N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>	



1

13790

13790

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13760

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newburg (Rural)</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Laura</b> First <b>Rogers</b> Middle Last				4. DATE OF DEATH Month <b>Dec.</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>George Dent</b>			
14. MOTHER'S MAIDEN NAME <b>Laura Maddox</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Arthur Rogers</b> Address <b>Newburg, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>12-16-'60</b>  <b>1953</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 15</b> , 19 <b>60</b> , to <b>Dec. 16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec. 15</b> , 19 <b>60</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>12-19-60</b>							
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.							
PHYSICIAN'S NAME (Type) <b>E. J. Edelen, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-19-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Rest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>La Plata, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home</b>				ADDRESS <b>Waldorf Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraw</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED CHARLES (Print or write full name)		SEX Male	
AGE 40		DATE OF BIRTH 1910	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Single		CAUSE OF DEATH (Specify)	
DATE OF DEATH 1950		PLACE OF DEATH Home	
TIME OF DEATH 10:00 AM		SIGNATURE OF PHYSICIAN (Signature)	
SIGNATURE OF REGISTRAR (Signature)		SIGNATURE OF WITNESS (Signature)	

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**13791 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ISSLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Issue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>RICHARD</b> First Middle Last				4. DATE OF DEATH <b>12 8 1960</b> Month Day Year			
5. SEX <b>H</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-15-02</b> 38 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>On Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>WALTER TEMPLEMAN</b>				14. MOTHER'S MAIDEN NAME <b>ANNA GANNON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes/</b>		17. INFORMANT <b>CHURCH RECORD</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>783.1</b> IMMEDIATE CAUSE (a) <b>LUNG HEMORRHAGE</b> DUE TO (b) <b>UNKNOWN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>12-8-60</b> <b>11-8-60</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E. J. EDELEN</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>12 8 60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/12/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Issue, Maryland</b>	
23. FUNERAL DIRECTOR <b>Archart Funeral Home, Inc. La Plata, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>DEC 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

MEDICAL CERTIFICATION

2

BC



13701  
MORTUARY

*[Faint, mostly illegible text and markings on a form, likely containing fields for patient information, medical history, and death details.]*



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X  
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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

13792

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13762

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bryantown</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Loretta</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5, 1960</u>
9. AGE (In years last birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Walter Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Edith Marie Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	
17. INFORMANT <u>Lewis W. Thompson, Bryantown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO Respiratory impairment Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12mo</u> <u>24hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12mo</u> <u>24hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-5</u> , 19 <u>60</u> , to <u>12-6</u> , 19 <u>60</u> that I last saw the deceased alive on <u>12-6</u> , 19 <u>60</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>LA PLATA, Md.</u> DATE SIGNED <u>7 Dec 60</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>LA PLATA, Md.</u> PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS <u>4000212XV2</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 12 60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1873

CERTIFICATE OF DEATH

No. 101

No. 101

Charles

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

Alfred

Age 1 day

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 1/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Md</i> b. COUNTY <i>CHAS.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO HADLOTTE HALL (RURAL)</i> d. STREET ADDRESS <i>1</i>					
3. NAME OF DECEASED (Type or print) <i>MARGARET LENORA WHALEN</i>						4. DATE OF DEATH Month <i>12</i> Day <i>14</i> Year <i>1960</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>C.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-19-60</i>		9. AGE (In years last birthday) <i>26</i>		IF UNDER 1 YEAR Months <i>12</i> Days <i>26</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOSEPH FANNON WHALEN JR</i>						14. MOTHER'S MAIDEN NAME <i>ANNE CHRISTINE PARKER</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Charles H. H. Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>PHONIC PNEUMONIA</i> (c) <i>12-12-60</i> 12-14-60 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH</i>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <i>12</i> o.m. <i>12</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>[Signature]</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>E. J. EDDLEN</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county) <i>12-14-60</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/15/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>				22d. LOCATION (City, town, or country) (State) <i>Newport, Maryland</i>			
23. FUNERAL DIRECTOR <i>Archart Funeral Home, Inc.</i> ADDRESS <i>La Plata, Md.</i>						24a. REC'D BY REGISTRAR <i>DEC 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

4000214XV5

1353

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13794

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13764

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf rural</b>		c. LENGTH OF STAY IN 1b <b>Waldorf rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>		d. STREET ADDRESS <b>Waldorf rural</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances Marie Willett</b> Middle <b>Frances Marie Willett</b> Last <b>Frances Marie Willett</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	11. IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew M. Gates</b>		14. MOTHER'S MAIDEN NAME <b>Florence Canter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Marie Adell</b>		Address <b>Accokeek, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RENAL Apoplexy</b> DUE TO <b>Cardio-Vas-Renal Dis &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Demility</b> (b) <b>Demility</b> (c) <b>Demility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> 19 <b>12-21</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12-19</b> 19 <b>60</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George Weber M.D.</b>		22b. DATE SIGNED <b>12-22-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Weber M.D.</b>		22d. ADDRESS <b>Waldorf, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

CERTIFICATE OF DEATH

1891

1891

Age

Sex

Color

Religion

Married

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

Sex

Color

Religion

Married

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

Sex

Color

Religion

Married

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

Sex

Color

Religion

Married

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

Sex

Color

Religion

Married

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

Sex

Color

Religion

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Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

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Cause of Death

Signature of Physician

Signature of Minister

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Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner

Age

Sex

Color

Religion

Married

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Minister

Signature of Coroner



## CERTIFICATE OF DEATH

Reg. Dist. No.

13765

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>		c. LENGTH OF STAY IN 1b .	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>MARY VIRGINIA WILLS</i>		4. DATE OF DEATH Month <i>12</i> Day <i>17</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-17-60</i>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min. <i>20</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Lewis Wills</i>		14. MOTHER'S MAIDEN NAME <i>Gracie Rebecca Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Joseph L. Wills - Potomac Heights, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Maternal (probable)</i> DUE TO (b) <i>mother had hypertension</i> DUE TO (c) <i>separation of placenta</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12-17-60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Brought to hospital with severe &amp; fatal placenta.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		DATE SIGNED <i>12/18/60</i>	
PHYSICIAN'S NAME (Type) <i>THE J. EDELEN</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/18/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Shilo Methodist Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Mt. Victoria, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>Archart Funeral Home, Inc., *La Plata, Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 30 '60</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5043

13796

## MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55

